AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION
FOR THE USE AND DISCLOSURE OF INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION

What happens when you are temporarily unable to or limited in your ability to participate in the New Hampshire Employment Program (NHEP)?

You have told us that your or your family member's health condition is a barrier to your participation in NHEP, the work program designed to help you prepare for and find employment. Your healthcare provider must provide us with documentation about your health condition so that it can be determined if you are fully, partially, or totally unable to participate in NHEP. You will receive two important forms to assist you with this:

1. This form, DFA Form 752A, *Authorization for Release of Protected Health Information*, which, with your permission, allows us to receive medical information from your healthcare provider(s); **and**
2. DFA Form 752, *Physician/Clinician Statement of Capabilities*, **OR** DFA Form 752HH, *Physician/Clinician Statement of Necessary Patient Care For a Household Member,* which your healthcare provider needs to complete and send directly to the Medical Exemption Unit (MEU) to document your or a family member's medical condition. The information your healthcare provider enters onto DFA Form 752/752HH will help us determine your ability to participate in NHEP or whether other programs may better help you with your healthcare needs.

You must sign DFA Form 752A and give it to your healthcare provider(s), while DFA Form 752/752HH must be filled out by your healthcare provider who must then return it directly to us. You are responsible for making sure that DFA Form 752A and DFA Form 752/752HH get to your healthcare provider. If you are applying or reapplying for Financial Assistance To Needy Families, DFA Form 752/752HH must be returned within 10 days of the date on the notice granting your eligibility. Otherwise, if you already participate in NHEP, you must continue to participate until DFA Form 752/752HH is returned and a decision is made on your status.

What you need to do:

- If your health condition limits your participation in NHEP, review and sign DFA Form 752A. Make a copy of it or keep the yellow sheet. Give the original signed DFA Form 752A and the DFA Form 752 to your healthcare provider.
- If your family member's health condition limits your participation in NHEP, have the family member review and sign DFA Form 752A. If the family member is your child, you may review and sign the DFA Form 752A on behalf of your child. Give the DFA Form 752HH and the original signed DFA Form 752A to your healthcare provider.
- Send the copy of the signed DFA Form 752A to DFA, NH DHHS, 129 Pleasant Street, Brown Bldg, Concord, NH 03301-3857, Attn: Medical Exemption Unit (MEU).
- Tell your healthcare provider that he or she must return the completed DFA Form 752/752HH directly to us within 10 days or you will be required to participate in work activities.
- Let us know if you are having difficulty in getting your healthcare provider to complete the form.

Once you have been found eligible for financial assistance, your medical information will be reviewed and, depending on your medical situation, a specialist from our Department may contact you and/or your doctor to determine if you have any ability to participate in the many activities and services offered by NHEP. The specialist may also identify other services that can help your family's specific medical situation.

If we do not receive a completed DFA Form 752/752HH directly from your healthcare provider, or your doctor has indicated that you can participate in NHEP, you will receive a letter scheduling you to attend a required NHEP appointment. If you have any questions about this process, you can contact the Medical Exemption Unit (MEU) at 1-800-852-3345 Ext. 9511.

Payment of any separate charge for completing this form is the responsibility of the patient. Charges solely for the completion of medical forms will not be paid by the Department of Health & Human Services.

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FOR THE USE AND DISCLOSURE OF INDIVIDUALLY INDENTIFIABLE HEALTH INFORMATION

PLEASE PRINT THE FANF INDIVIDUAL'S NAME, RECIPIENT IDENTIFICATION (RID) NUMBER, & CASE NUMBER – ALSO PRINT THE FAMILY MEMBER'S NAME IF THE FANF INDIVIDUAL IS CLAIMING A MEDICAL EXEMPTION FOR CARING FOR A HOUSEHOLD MEMBER.

FANF Individual	RID #
Family Member Name, if applicable	Case #

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that the information I authorize a person or entity to receive may be re-disclosed and no longer protected by federal privacy regulations.

This authorization expires 12-months from the date this form is signed.

Persons/organizations authorized to use and/or disclose the information: Health Care Provider

Persons/organizations authorized to receive the information: New Hampshire Department of Health & Human Services (DHHS), including contract staff.

Specific description of information that may be used/disclosed: Information specifying capacities, environments, activities and/or limitations to participate in New Hampshire Employment Program (NHEP) work-related activities such as job readiness classes, education, vocational training, on-the-job training and actual employment.

The information will be used/disclosed for the following purposes: Information will be used to determine the individual's ability to participate in any work-related activities available through NHEP.

I understand that this authorization is voluntary and that I may refuse to sign this authorization. I further understand that my refusal to sign this authorization may result in a determination that I am a mandatory participant in the NHEP work program. I understand that I may revoke this authorization at any time by notifying DHHS in writing. However, the revocation will not be valid if:

1. DHHS has already taken action based upon this authorization; or
2. This authorization is obtained as a condition for obtaining insurance coverage; other law provides the insurer with the right to contest a claim under the policy or the policy itself.

Please sign below.

Signature of Applicant/Recipient/Family Member or Authorized Representative _____ Date _____

Printed Name of Applicant/Recipient/Family Member or Authorized Representative _____

If the individual signing the release is an authorized representative, please attach the appropriate legal documentation, such as the DFA Form 778, Authorized Representative (AR) Declaration.

For DHHS Use Only

If the individual signing this release is an authorized representative, your signature below certifies that you have verified the authorized representative's identity.

Signature/Title _____ Date _____